

***United States Court of Appeals  
for the Second Circuit***



**APPELLEE'S BRIEF**





ORIGINAL

77-6174

IN THE  
UNITED STATES COURT OF APPEALS  
FOR THE SECOND CIRCUIT

B

No. 77-6174

HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., MISERICORDIA  
HOSPITAL MEDICAL CENTER and BUFFALO GENERAL HOSPITAL, THE  
GENESEE HOSPITAL, and THE MOUNT SINAI HOSPITAL on behalf  
of themselves and all other nonprofit hospitals which are  
members of the HOSPITAL ASSOCIATION OF NEW YORK STATE,  
INC., and which are reimbursed for Medicaid Services  
rendered to hospital patients,

P/S

Plaintiffs-Appellants,

v.

PHILIP L. TOIA, as Commissioner of Social Services of the  
State of New York, ROBERT P. WHALEN, as Commissioner of  
Health of the State of New York, PETER GOLDMARK, as  
Director of the Budget of the State of New York, HUGH L.  
CAREY, as Governor of the State of New York,

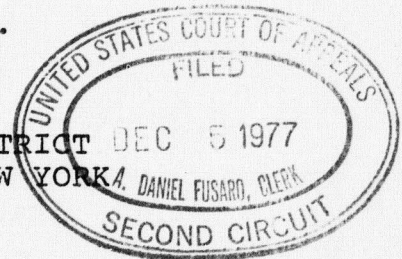
Defendants-Appellees,

and

F. DAVID MATHEWS, as Secretary of the United States  
Department of Health, Education and Welfare,

Defendant.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT  
FOR THE SOUTHERN DISTRICT OF NEW YORK



BRIEF OF STATE DEFENDANTS-APPELLEES

LOUIS J. LEFKOWITZ  
Attorney General of the State of New York  
CHARLES A. MILLER  
ROBERT N. SAYLER  
PATRICIA A. BARALD  
MARK I. LEVY  
Special Assistant Attorneys General  
Covington & Burling  
888 Sixteenth Street, N. W.  
Washington, D. C. 20006

Attorneys for State Defendants-Appellees



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IN THE  
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FOR THE SECOND CIRCUIT

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No. 77-6174

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HOSPITAL ASSOCIATION OF NEW YORK STATE, INC., et al.,  
Plaintiffs-Appellants,  
v.  
PHILIP L. TOIA, et al.,  
Defendants-Appellees,  
and  
F. DAVID MATHEWS, as Secretary of the U.S. Department of  
Health, Education and Welfare,  
Defendant.

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ON APPEAL FROM THE UNITED STATES DISTRICT  
COURT FOR THE SOUTHERN DISTRICT OF NEW YORK

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BRIEF OF STATE DEFENDANTS-APPELLEES

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STATEMENT OF ISSUE PRESENTED

Whether the District Court abused its  
discretion in dismissing this action against the State  
Defendants when the 1976 methodology initially challenged  
by the hospitals was substantially revised for 1977 and



the hospitals refused to amend their complaint to contest the currently operative 1977 methodology.

PRELIMINARY STATEMENT

This appeal need not long detain the Court, for it is not a case where the State Defendants are trying to avoid litigating the present issues between the parties -- the issues underlying the provisions that the appellant hospitals characterize as "the substance of the State Plan being administered today" (Pl. Br., p. 31) and which they claim to be the issues they want to litigate. Nor is it a case where, in the first instance, the State Defendants sought dismissal. Rather, after the District Court decided that the Eleventh Amendment bar to retrospective relief was applicable and that its jurisdiction was limited to claims for prospective relief, the State Defendants expressed the view that the subject of the trial should be the 1977 reimbursement formula currently in effect, which had significantly changed from the 1976 plan that the hospitals had originally challenged. It was pointed out that while the aspects of the 1976 plan principally attacked by the hospitals had been continued in 1977, many were significantly affected by the 1977 changes so that the record developed to date in the pre-trial proceedings, so far as prospective relief was concerned (the



only relief available in the circumstances), was stale and incomplete.

For reasons yet to be explained, the hospitals refused to amend their complaint and steadfastly insisted on trying solely the validity of the 1976 formula. Only after this position was repeatedly confirmed did the court below invite a motion to dismiss and, upon its filing by the State Defendants and continued adherence by the hospitals to their position, exercise its discretion to dismiss the case because it was inappropriate for trial in the limited manner demanded by the hospitals.

In these circumstances, the issue of mootness, to which the hospitals devote their entire extended brief in this Court, has little if any pertinence. The question, rather, is whether the District Court abused its discretion in declining to try the case on a stale and incomplete record. Since the hospitals have not tried to and could not mount a valid objection to the District Court's exercise of discretion, the court's order of dismissal should be affirmed.

#### STATEMENT OF THE CASE

The instant appeal has been consolidated with Docket No. 77-6152, and the State Defendants respectfully refer the Court to the "Statement of the Case" contained



in its brief in that appeal for the background pertinent to this appeal.

This suit was initiated in 1976 to challenge the methodology utilized by New York to reimburse hospitals for services provided under the Medicaid program. The hospitals obtained orders precluding the state from applying its reimbursement formula as amended in 1976 until the amendments were approved by HEW and directing the state to recompute payments for 1976 in accordance with the pre-existing methodology until HEW approved the 1976 amendments. The approval occurred, for most of the amendments in issue, in August 1976, and the case continued for consideration of the hospitals' challenge to the amended formula as approved by HEW.

The formula was again substantially amended effective April 1, 1977, and the amendments were approved by HEW. (Supp. J.A. 17, 29-70).<sup>\*/</sup> The District Court was informed of the amendments and of HEW's approval. (J.A. 15-16, 27-28). Subsequently, on August 4, 1977, the District Court on remand from this Court decided the Eleventh Amendment questions that are the subject of the

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<sup>\*/</sup> HEW's approval was subject to certain conditions which were satisfied by the state. (Supp. J.A. 17, 27-29).



hospitals' appeal in No. 77-6152. The ruling that the court was precluded from retrospective relief and could only entertain requests for prospective relief raised the question whether it was appropriate to continue litigating the validity of the 1976 formula since it had been superseded by the 1977 formula. The State Defendants had raised this issue on several previous occasions (J.A. 642-43, 645-46, 720), and at a chambers conference following the Eleventh Amendment ruling the issue again arose and was fully explored. (J.A. 718-47). Thereafter, the parties submitted letters to the court explaining their positions. (J.A. 798-812, 825-31, 877-78). In these communications the hospitals took the position that the 1977 amendments to the formula were irrelevant and could not be considered by the court (J.A. 811-12) and that they wanted to try only the validity of the formula as it existed in 1976 following HEW approval. Under these circumstances, the District Court indicated its inclination to dismiss the case against the State Defendants in the exercise of its discretion in light of the Eleventh Amendment limitations on the prohibition against retrospective relief and the fact that the 1976 formula had been superseded. It invited the State Defendants to submit a motion to dismiss. (J.A. 776, 779, 783).



After the motion had been made and answered (J.A. 790, 818), the District Court dismissed the case as to the State Defendants on October 13, 1977, finding that the 1976 formula had "undergone substantial revision in 1977" and that, since the hospitals' challenge related only to the 1976 methodology, "the record before us is both incomplete and stale." (J.A. 888; Appendix A hereto<sup>\*/</sup>). The court characterized the challenge to the state's reimbursement formula for Medicaid services as involving "a matter of substantial public importance" which, "at least prospectively, could involve large sums of public money. 'Adjudication of such problems, certainly by way of resort to a discretionary declaratory judgment, should rest on an adequate and full-bodied record. The record before us is woefully lacking in these requirements.' Public Affairs Press v. Rickover, 369 U.S. 111 (1962)." (Appendix A).

The District Court declined to dismiss as to the federal defendant (HEW), concluding that, because the approval process was recurring, it could properly review the procedural aspects of HEW's approval of the

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<sup>\*/</sup> The District Court's opinion on dismissal, dated November 18, 1977, was not included in the Joint Appendix but is appended hereto in Appendix A.



1976 state plan amendments and establish standards to guide that process in the future. (Appendix A). Trial of this matter commenced in October, has proceeded intermittently, and is expected to conclude in early December.

On October 14, 1977, the District Court directed that its order of dismissal of the State Defendants be entered as a final judgment under Fed. R. Civ. P. 54(b). This appeal followed.

#### ARGUMENT

THE DISTRICT COURT DID NOT ABUSE ITS DISCRETION IN DISMISSING THIS ACTION AGAINST THE STATE DEFENDANTS IN LIGHT OF THE HOSPITALS' INSISTENCE ON CONFIRMING THEIR CHALLENGE TO A SUPERSEDED REIMBURSEMENT FORMULA.

A. The Hospitals' Arguments Concerning Mootness Are Beside The Point And Do Not Bear On The District Court's Discretion To Dismiss The Case.

The main argument of the hospitals is that their challenge to the 1976 reimbursement formula is not moot in the constitutional sense because a live controversy continues between the parties as to many of the provisions added in 1976 that remain in the formula. (Pl. Br., pp. 26-41). This argument is beside the point because it misconstrues both the basis for the dismissal



motion ultimately made by the State Defendants and the District Court's ground of dismissal.

Dismissal was sought and granted on the ground that, as a matter of discretion, the court should decline to try this case, which raises substantial issues of great public importance, on a stale and incomplete record. At no point did the District Court conclude that there was not a live controversy between the parties. Rather, the court recognized that it was confined to the award of prospective relief because of the state's Eleventh Amendment immunity, and determined that its equity jurisdiction should be exercised only if it could, depending on the proof, award meaningful prospective relief. That was not possible so long as the hospitals refused to litigate the presently effective formula, particularly in light of the changes to the formula in 1977 and the new HEW consideration and approval that would bear heavily on the ability of the hospitals to prove a case for prospective relief.

The District Court's exercise of its discretion was not limited by strict legal concepts of mootness, and the hospitals' arguments about mootness do not address the grounds of the District Court's action. Thus, the hospitals' argument (Pl. Br., pp. 29-31) that most of the important provisions added in 1976 remain part of the formula is



irrelevant. The State Defendants have never contended that the 1977 formula eliminates the controversy between the parties concerning the elements of the 1976 formula questioned by the hospitals. The State Defendants are prepared to defend all of those provisions on the merits, as well as any other aspects of the present formula that the hospitals may challenge. They expected to do so in this litigation until the hospitals refused to consider the 1977 methodology.

Notwithstanding their admission to this Court that the provisions they are challenging "embody the substance of the State Plan being administered today" (Pl. Br., p. 31; see also id., p. 35), the hospitals have never offered any reason for not litigating the issues that concern them in the context of the present formula. The only apparent reason is the impermissible one (see pp. 22-24 below) of attempting to secure an adjudication of the 1976 formula that could be used as the basis for an action in a state forum to recover additional reimbursement for 1976. The District Court was clear that it would not permit the hospitals to proceed for this purpose (J.A. 733), and this decision was also, at the least, within the court's discretion.



B. The District Court's Exercise Of Discretion Was Soundly Based.

The considerations relied upon by the District Court to dismiss the case against the State Defendants fully support its action.

That the reimbursement formula had undergone substantial revision in 1977 is really not disputable. In this connection, it should be recognized that while the 1976 changes were also substantial, they did not alter the basic character of the formula. Since 1970, the state has employed a prospective reimbursement methodology under which rates are determined in advance of the period of service based on past costs projected forward. Among other things, the New York methodology utilized the concept of "ceilings" on certain categories of costs based on comparisons between a particular hospital and the average of those costs experienced by a peer group. The major 1976 changes reduced the ceiling rate for "routine" costs from 110 percent to 100 percent and added a ceiling at the 100 percent level for "ancillary" costs. The main other changes covered the method by which the state projected base period costs, the process by which hospitals could appeal their rates, and specific items of cost included in the formula.



These changes were part of a major effort by the state to reduce wasteful expenditures and to enforce more efficient operation by hospitals. The rising cost of health care, particularly in government-funded programs, had by 1976 become a major issue of national focus and was particularly critical in New York where the burgeoning cost of state programs threatened the state's fiscal soundness. Medicaid was and is the largest state program, and reimbursement to the hospitals represents the largest component of the state's Medicaid expenditures.

The state's efforts toward hospital cost containment were not all included in the 1976 changes. Other steps to strengthen and improve the program were incorporated into the payment formula in early 1977. These included principally the addition of another ceiling to disallow costs attributable to excessive lengths of stay and a new method of grouping hospitals for the purpose of applying the various ceilings. (Supp. J.A. 48-50). While the formula has subsequently undergone further amendments, many of which were designed to adopt suggestions made on behalf of the hospitals, and additional improvements may be developed in the future, the principal changes of 1976 and early 1977 represent the major steps taken by the state to control and rationalize Medicaid expenditures for hospital services.



The hospital industry clearly recognized the significance of the sets of changes in 1976 and early 1977. Both involved substantial consideration by HEW prior to approval. Hospital representatives, including the Hospital Association of New York State (HANYS), the association of voluntary and public hospitals which is a plaintiff-appellant in this case, made substantial presentations to HEW in connection with both sets of changes. (Supp. J.A. 14, 79-136). The submission on the 1977 plan characterizes the amendments as "numerous proposals for substantial revision." (Supp. J.A. 14).

Adoption of the 1977 changes has already provoked litigation. The hospitals sought immediately to thwart the changes on the ground that they had been adopted in an unlawful manner by the state. This effort was unsuccessful. New York University and Ellis Hospital v. Whalen, Index No. 2031/77 (Sup. Ct., New York, May 20, 1977), aff'd, \_\_\_\_\_ (App. Div., 1st Dept., 1977). Within the last few months, cases have been filed in both state and federal court challenging aspects of the 1977 formula on the merits. New York City Health and Hospitals Corp. v. Califano, 77 Civ. 4483 (S.D.N.Y., filed September 12, 1977) (KTD); Brooklyn Hospital v. Whalen, Index No. 16058/77 (Sup. Ct., Kings County, filed July 27, 1977).



The District Court was aware of the foregoing when it determined to dismiss the case against the State Defendants. The 1977 formula showing the changes from the 1976 version had been before the court since its approval by HEW on March 31, 1977. (Supp. J.A. 15-16, 30-70).

While changes in the 1977 formula affect many of the provisions challenged by the hospitals, one of great significance was the change in the method of grouping hospitals for purposes of applying the ceilings. A major hospital objection to the 1976 ceilings was that they were based on unsophisticated groupings of hospitals that failed to take account of the factors that would explain differences in hospital costs. The change incorporated in 1977, which reflected a significant advancement in the field of health economics, adopted an entirely new grouping method based on computer analysis that took account of many more factors than had been considered under the previous formula. (See Supp. J.A. 46-48). Thus, this change has a significant bearing on the operation of the routine and ancillary ceilings which are the main focus of the hospitals' attack in this case.<sup>\*/</sup> At

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<sup>\*/</sup> In its Memorandum of October 13, 1977, denying plaintiffs' motion for summary judgment, the District Court recognized that the validity of the ceiling provisions could not be judged independently of the grouping method (Memorandum at 6 & n.4).



the very least, District Judge Lasker was certainly correct in concluding that the 1977 amendments were sufficiently substantial to require examination and consideration before the validity of the formula could be determined.

The hospitals are careful not to deny that the 1977 changes were substantial. They argue here simply that the 1977 changes do not obviate the issues they seek to raise concerning the provisions adopted in 1976. (Pl. Br., pp. 31-33). That may or may not be, but it does not answer the District Court's point that the 1977 changes were sufficiently substantial to be taken into account in weighing the validity of the formula.

Based on the foregoing, it is clear that the record to date in the District Court was too stale and incomplete to test the validity of the state's formula and allow meaningful relief to be entered. That record -- based on pre-trial discovery -- is confined to the 1976 formula, a methodology that had been superseded and was no longer in effect. While the material developed so far would undoubtedly be pertinent to consideration of the validity of the present formula, it does not represent the full story. Given the major public importance of the case, the court below was properly unwilling to decide it on the basis of an insufficient record. Since the case was



still in the pre-trial stages, and in light of the absence of any valid explanation for the hospitals' refusal to litigate their challenge in the context of the present formula, the District Court properly declined to go forward with the case.

In contrast to the hospitals, which have offered no valid explanation for insisting that only the superseded 1976 plan be tried, the state has a substantial interest in avoiding such piecemeal litigation, which does not allow either adequate consideration of the concept and operation of the methodology or the entry of a dispositive judgment. The Medicaid program has already imposed unusually heavy litigation burdens on the state. Requiring the state to go through a major trial on the essentially academic question of the validity of the 1976 formula would be totally unwarranted, particularly when there is no good reason not to try the issues once and for all in the context of the current formula, the only context within which the court can make a dispositive judgment.

C. Case Law Clearly Supports The  
District Court's Exercise Of  
Discretion.

The existence and exercise of the District Court's discretion in this case are well supported by legal authority. Even when a case involving injunctive or declaratory relief is not technically moot, there resides in the federal



courts a broad discretion to decline to proceed with the case based on considerations of equity or of sound judicial administration.<sup>\*/</sup> In a wide variety of circumstances, courts have recognized the existence and applicability of this discretion. See, e.g., Public Affairs Associates, Inc. v. Rickover, 369 U.S. 111 (1962); United States v. W.T. Grant Co., 345 U.S. 629, 633 (1953); Panama Processes, S.A. v. Cities Service Co., 496 F.2d 533 (2d Cir. 1974), aff'g 362 F. Supp. 735 (S.D.N.Y. 1973); National Health Federation v. Weinberger, 518 F.2d 711 (7th Cir. 1975); Wilderness Society v. Morton, 479 F.2d 842, 886-87 (7th Cir. En Banc 1973), cert. denied, 411 U.S. 917 (1973); Alton & So. Ry. Co. v. International Ass'n of Mach. & A.W., 463 F.2d 872, 877, 880, 882 (D.C. Cir. 1972). As the Court said in W.T. Grant Co., supra:

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<sup>\*/</sup> In contrast, mootness is a constitutional doctrine derived from the "case or controversy" requirement of Article III, and as such it goes to the very power of federal courts to adjudicate. See, e.g., Preiser v. Newkirk, 422 U.S. 395, 401-02 (1975); DeFunis v. Odegaard, 416 U.S. 312, 316 (1974); SEC v. Medical Committee for Human Rights, 404 U.S. 403, 407 (1972). When a case becomes moot, "the defendant is entitled to a dismissal as a matter of right," United States v. W.T. Grant Co., 345 U.S. 629, 632 (1953).

There is an argument here that the case is technically moot because the 1976 methodology has been superseded and is no longer in effect as it was in 1976. However, this argument was neither pressed by the State Defendants nor relied on by the District Court as the basis of the dismissal.



"Along with its power to hear the case [because it is not technically moot], the court's power to grant injunctive relief survives discontinuance of the illegal conduct. Hecht Co. v. Bowles, *supra*; Goshen Mfg. Co. v. Myers Mfg. Co., 242 U.S. 202 (1916). The purpose of an injunction is to prevent future violations, Swift & Co. v. United States, 276 U.S. 311, 326 (1928), and, of course, it can be utilized even without a showing of past wrongs. But the moving party must satisfy the court that relief is needed. The necessary determination is that there exists some cognizable danger of recurrent violation, something more than the mere possibility which serves to keep the case alive. The chancellor's decision is based on all the circumstances; his discretion is necessarily broad and a strong showing of abuse must be made to reverse it." 345 U.S. at 633.

Among the factors to be considered by a district court in exercising this discretion are the availability of meaningful judicial relief as a result of the litigation (e.g., Alton & So. Ry. Co. v. International Ass'n of Mach. & A.W., *supra*, 463 F.2d at 877), the need to conserve scarce judicial time and resources in the face of increasingly crowded dockets (e.g., National Health Federation v. Weinberger, *supra*, 518 F.2d at 713; United States v. Hooper, 432 F.2d 604, 606 (D.C. Cir. 1970)), the avoidance of piecemeal litigation (e.g., National Health Federation v. Weinberger, *supra*, 518 F.2d at 713; Panama Processes, S.A. v. Cities Service Co., *supra*, 362 F. Supp.



at 738), and the adequacy of the record to support adjudication on matters of public importance (Public Affairs Associates, Inc. v. Rickover, supra, 369 U.S. at 112-13). These were the very factors on which the court below predicated its dismissal order.

Fusari v. Steinberg, 419 U.S. 379 (1975), illustrates the inappropriateness of granting declaratory or injunctive relief against a statute or regulation that has been revised or superseded in material measure. There, after a lower court had invalidated Connecticut's procedure for determining continued eligibility for unemployment compensation and the case was on appeal to the Supreme Court, Connecticut by statute revised the procedures in an effort to remedy the problem identified by the court. In view of the intervening change in state law, the Supreme Court vacated the lower court judgment. Citing its duty to review the case "in light of presently existing Connecticut law, not the law in effect at the time that judgment was entered" (419 U.S. at 387), the Court found that it was "unable meaningfully to assess the issues in this appeal on the present record" (id.) because "[w]hile we can determine on this record that Connecticut's previous system often failed to deliver benefits in a timely manner, we can only speculate how the new system might operate" (419 U.S. at 388-89). Accordingly, it remanded to



the lower court to consider the effect of the statutory change.<sup>\*/</sup>

Similarly, in Hagans v. Wyman, 527 F.2d 1151 (2d Cir. 1975), subsequent opinion, 536 F.2d 525 (2d Cir. 1976), this Court vacated a district court's judgment and remanded because of intervening changes in Connecticut's AFDC program, but indicated that any possible mootness issue could be avoided if the new state law were brought before the District court. Likewise, here the hospitals could have avoided the District Court's discretionary dismissal simply by amending their complaint to bring the current version of the reimbursement formula before the court. In this case, the change occurred well before trial, making the District Court's decision not to proceed under the superseded formula even more compelling.

The hospitals cite a line of cases holding that judicial review cannot be avoided on mootness grounds where the challenged action is "capable of repetition, yet

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<sup>\*/</sup> As the Supreme Court noted in Richardson v. Wright, 405 U.S. 208, 209 (1972), in vacating and remanding to the district court in light of an intervening change in the challenged HEW regulations:

"In the context of a comprehensive complex administrative program, the administrative process must have a reasonable opportunity to evolve procedures to meet needs as they arise."



evading review." (Pl. Br., pp. 37-41). Since the dismissal was not predicated on mootness, these cases are beside the point. In any case, the doctrine is inapplicable because the changes to state's formula had neither the purpose nor effect of evading review on the issues raised by the hospitals. Rather, the hospitals concede that the present formula embodies the provisions they seek to challenge. (Pl. Br., pp. 31, 35). In addition, there is virtually no likelihood that the state would return to the formula utilized in 1976. The mere abstract possibility of such a return does not satisfy the "capable of repetition" test. See Preiser v. Newkirk, 422 U.S. 395, 403 (1975).<sup>\*/</sup>

It is true that the state's reimbursement formula is changed periodically. Sometimes the changes are major; more frequently they involve minor refinements or technical improvements. The 1977 changes were major and because of this the District Court concluded that it would be inappropriate to continue to litigate the 1976 version. (See J.A. 725). But this does not

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<sup>\*/</sup> The hospitals' continued reference to the "blatant disregard" phrase used by the District Court is completely irrelevant. That phrase was used in connection with the state's implementation of its 1976 formula changes prior to their submission to HEW for approval. (J.A. 713). It was entirely unrelated to the court's dismissal action.



mean that every change in the formula will frustrate judicial review. District courts clearly have broad discretion to decide in particular cases the importance of the changes and their effect on the litigation. In this case, the District Court's decision, as a matter of discretion, not to proceed when the hospitals refused to take account of very substantial changes made well before trial was clearly reasonable.

In connection with their irrelevant mootness arguments, the hospitals contend that the State Defendants failed to make an adequate record in the District Court to support the dismissal. This contention is insupportable both in fact and in law.<sup>\*/</sup> The hospitals had the burden of demonstrating that their challenge was sufficiently immediate and the prospect of meaningful equitable relief sufficiently great, notwithstanding the 1977 changes, to justify going forward. See United States v. W.T. Grant Co., 345 U.S. 629, 633 (1953). This they failed to do. But even if the burden were on the State Defendants, it was fully met. The fact of the 1977

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<sup>\*/</sup> Moreover, to the extent that this contention is accepted by this Court, the proper disposition of the appeal would be to remand to the District Court for appropriate factual determinations, not to remand "for a trial on the merits". (Pl. Br., pp. 4, 51).



amendments alone was sufficient to give rise to an inference that the 1976 methodology had been superseded. See Kaye v. Funding Systems Corp., Docket Nos. 76-7272, 76-7544 (2d Cir., June 20, 1977), slip op. at 4265, opinion vacated by order of the Court. And beyond this inference, the District Judge's conclusion that the amendments had substantial bearing on the issue in the case derived not only from his intimate familiarity with the case but from the terms of the amendments, which were before him, and the significance attached to them by HANYS and those hospitals that have already instituted suits challenging them.

In sum, the hospitals have failed to advance any valid legal objection to the District Court's exercise of discretion in this case.

D. There Is No Proper Relief That  
A Federal Court May Grant Con-  
cerning The 1976 Formula.

The hospitals contend that the dismissal was in error because the District Court could enter a declaratory judgment against the State Defendants which would serve as the basis for monetary relief in state court. (Pl. Br., pp. 47-51). Even if such a judgment were permissible, this argument does not show that the District Court abused its discretion in dismissing the



case. But the hospitals' main premise is wrong. Under the Eleventh Amendment, a federal court may not adjudicate rights where the sole purpose is to establish a basis for monetary liability of the state for a past period. See Edelman v. Jordan, 415 U.S. 651 (1974); Jordan v. Trainor, Docket No. 75-1908, 46 U.S.L.W. 2245 (7th Cir. In Banc Oct. 19, 1977), aff'g in pertinent part 551 F.2d 152 (7th Cir. 1977). This type of declaratory relief would accomplish indirectly what is not permitted directly, for it would be tantamount to a "determination of whether or not past benefits were in fact due from the state" (Jordan v. Trainor, supra, slip op. at 4) and would contravene the mandate of the Eleventh Amendment that the state "determine for itself by its own procedures whether any back payment may be due" (id., slip op. at 8).<sup>\*/</sup>

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\*/ The In Banc opinion in Jordan v. Trainor indicated that an order requiring the state to advise welfare recipients of their procedural rights with respect to past payments would not be barred by the Eleventh Amendment. The court recognized that this proposition was at least questionable, and that a contrary result had been reached in Fanty v. Commonwealth of Pennsylvania Department of Public Welfare, 551 F.2d 2 (3d Cir. 1977). The relief sought by the hospitals here is not of this character. Their procedural rights of appeal are clearly set forth in the state plan and departmental regulations, and they do not and could not claim ignorance of them. Rather, the hospitals seek relief that would force a state court to award them monetary relief. Their claim is the same in substance as the requirement of the lower court in Jordan v. Trainor that the state concede monetary liability for past periods. Even the In Banc opinion in Jordan found that this relief was barred by the Eleventh Amendment.



Moreover, apart from the Eleventh Amendment, it is inappropriate for a federal court of equity either to rule upon issues that are within the exclusive purview of another tribunal (and particularly a state tribunal) or to enter declaratory relief for the sole and express purpose of supporting subsequent litigation in another forum. See Public Service Comm'n v. Wycoff Co., 344 U.S. 237 (1952); General Electric Co. v. Local 761, IUE, 395 F.2d 891 (6th Cir. 1968); Local No. 2 v. Paramount Plastering, Inc., 310 F.2d 179 (9th Cir. 1962), cert. denied, 372 U.S. 944 (1963); Ove Gustavsson Contracting Co. v. Floete, 278 F.2d 912 (2d Cir.), cert. denied, 364 U.S. 894 (1960); Shank v. NLRB, 260 F.2d 444 (7th Cir. 1958).

Thus, the District Court was clearly correct in refusing to proceed to trial on the 1976 reimbursement formula solely for the purpose of entering a federal declaratory judgment to support the hospitals' claim for retrospective monetary relief in state court.\*

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\*/ The hospitals' brief, in the "Statement of Facts" (Pl. Br., pp. 9-23) and elsewhere (Pl. Br., pp. 29-31), contains extended argument in support of the hospitals' contention that certain provisions of the reimbursement formula are invalid. Since the validity of these provisions has yet to be tried, it is not surprising that the argument is devoid of a single citation to the record or any other authority. The merits of the state's formula are not before the Court

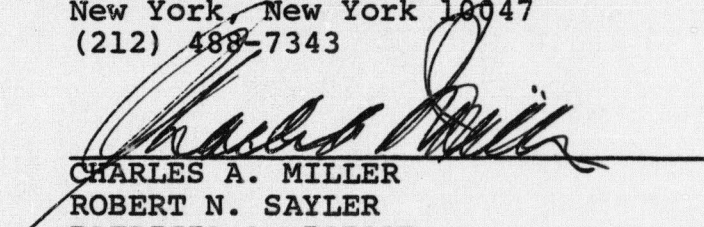


CONCLUSION

For the foregoing reasons, the District Court's order of dismissal of the State Defendants should be affirmed.

Respectfully submitted,

LOUIS J. LEFKOWITZ  
Attorney General of the  
State of New York  
Two World Trade Center  
New York, New York 10047  
(212) 488-7343



CHARLES A. MILLER  
ROBERT N. SAYLER  
PATRICIA A. BARALD  
MARK I. LEVY  
Special Assistant Attorneys General  
Covington & Burling  
888 Sixteenth Street, N. W.  
Washington, D. C. 20006  
(202) 452-6000

Attorneys for State  
Defendants-Appellees

December 5, 1977

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(Footnote cont'd)

in this appeal and will not be argued in this brief. However, the state is confident that its formula, including the provisions attacked by the hospitals, will withstand any challenge. In the event the Court is interested in the nature of the state's defense on the merits, there is contained in Appendix B hereto an outline of the justification for the provisions identified in the hospitals' brief.



APPENDIX A



UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF NEW YORK

-----X  
HOSPITAL ASSOCIATION OF NEW YORK STATE,  
INC., MISERICORDIA HOSPITAL MEDICAL  
CENTER, BUFFALO GENERAL HOSPITAL, THE  
GENESEE HOSPITAL, and THE MOUNT SINAI  
HOSPITAL on behalf of themselves and  
all other nonprofit hospitals which  
are members of the HOSPITAL ASSOCIATION  
OF NEW YORK STATE, INC. and which are  
reimbursed for Medicaid services  
rendered to hospital patients,

76 Civ. 2027

Plaintiffs,

--against--

PHILIP L. TOIA, as Commissioner of  
Social Services of the State of New York,  
ROBERT P. WHALEN, as Commissioner of  
Health of the State of New York, PETER  
GOLDMARK, as Director of the Budget of  
the State of New York, HUGH L. CAREY,  
as Governor of the State of New York,  
and DAVID MATHEWS, as Secretary of the  
U.S. Department of Health, Education  
& Welfare,

Defendants.  
-----X

APPEARANCES:

PROSKAUER, ROSE, GOETZ & MENDELSON, ESQS.  
300 Park Avenue  
New York, New York 10022  
Attorneys for Plaintiffs

Of Counsel: JACOB IMBERMAN, ESQ.  
ROBERT KAUFMAN, ESQ.  
STEVEN S. MILLER, ESQ.  
SUSAN C. ROSENFELD, ESQ.  
M. WILLIAM SCHERER, ESQ.

ROSENMAN, COLIN, FREUND, LEWIS & COHEN, ESQS.  
575 Madison Avenue  
New York, New York 10022  
Attorneys for the New York City Health and Hospitals  
Corporation  
Of Counsel: PETER F. NADEL, ESQ.



LOUIS J. LEFKOWITZ, ESQ.  
Attorney General of the State of New York  
Two World Trade Center  
New York, New York 10047  
Attorney for State defendants

Of Counsel: COVINGTON & BURLING, ESQS.  
888 Sixteenth Street, N.W.  
Washington, D. C. 20006

ROBERT B. FISKE, JR., ESQ.  
United States Attorney for the Southern District  
of New York  
One St. Andrews Plaza  
New York, New York 10007  
Attorney for U.S. Department of Health, Education  
and Welfare

Of Counsel: JOHN O'CONNOR, ESQ.  
Assistant United States Attorney



LASKER, D.J.

In the wake of our Opinion of August 4, 1977, ordering that the money judgment against the state defendants of August 2, 1976 be vacated because of Congress' repeal of the requirement that the state defendants waive their Eleventh Amendment immunity (\_\_\_ F.Supp. \_\_\_), the state defendants have moved to dismiss the case as moot, or, in the alternative, to dismiss the complaint, except with respect to the issue of whether the approval of the Secretary of the Department of Health, Education and Welfare of the 1976 State plan for inpatient hospital service reimbursement was deficient because of inadequate consideration or faulty approval procedures.

The primary motion is denied and the alternative motion is granted. We agree with the state defendants that since the order vacating the August 2, 1976 judgment precludes any monetary relief against the state in this court and since the complaint relates only to provisions of the State's 1976 methodology for reimbursing hospitals, a methodology which has undergone substantial revision in 1977, the record before us is both incomplete and stale.

The plaintiffs' claim that the State's 1976 methodology for determining reimbursements of hospital Medicaid expenses violates the federal statute, involves a matter of substantial public importance and, at least prospectively,



could involve large sums of public money. "Adjudication of such problems, certainly by way of resort to a discretionary declaratory judgment, should rest on an adequate and full-bodied record. The record before us is woefully lacking in these requirements." Public Affairs Press v. Rickover, 369 U.S. 111 (1962).

On September 14, 1977, at a conference with counsel, we stated our views on this subject more fully. Reference is made to that transcript so that the appeal from this order of dismissal can be expedited and consolidated with plaintiffs' appeal from our order vacating the judgment of August 2, 1976.

The complaint is dismissed as to Philip L. Toia, as Commissioner of Social Services of the State of New York, Robert P. Whalen, as Commissioner of Health of the State of New York, Peter Goldmark, as Director of the Budget of the state of New York, and Hugh L. Carey, as Governor of the State of New York.

It is so ordered.

Dated: New York, New York  
November 18, 1977.

MORRIS E. LASKER

---

U.S.D.J.



UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF NEW YORK

-----X

HOSPITAL ASSOCIATION OF NEW YORK STATE,  
INC., MISERICORDIA HOSPITAL MEDICAL  
CENTER, BUFFALO GENERAL HOSPITAL, THE  
GENESEE HOSPITAL, and THE MOUNT SINAI  
HOSPITAL on behalf of themselves and  
all other nonprofit hospitals which  
are members of the HOSPITAL ASSOCIATION  
OF NEW YORK STATE, INC. and which are  
reimbursed for Medicaid services  
rendered to hospital patients,

76 Civ. 2027

Plaintiffs,

-against-

DAVID MATHEWS, as Secretary of the  
U.S. Department of Health, Education  
and Welfare,

Defendant.

-----X

APPEARANCES:

PROSKAUER, ROSE, GOETZ & MENDELSON, ESQS.  
300 Park Avenue  
New York, New York 10022  
Attorneys for Plaintiffs

Of Counsel: JACOB IMBERMAN, ESQ.  
ROBERT KAUFMAN, ESQ.  
STEVEN S. MILLER, ESQ.  
SUSAN C. ROSENFELD, ESQ.  
M. WILLIAM SCHERER, ESQ.

ROBERT B. FISKE, JR., ESQ.  
United States Attorney for the Southern District  
of New York  
One St. Andrews Plaza  
New York, New York 10007  
Attorney for Defendant

Of Counsel: JOHN O'CONNOR, ESQ.  
Assistant United States Attorney



LASKER, D.J.

Following the court's indication at its conference with counsel on the record September 14, 1977, that it would grant a motion to be made by the state to dismiss the complaint as to the state defendants, the Secretary of Health, Education and Welfare has moved to dismiss the case as to him on grounds of mootness. The motion is denied.

As explained on the record at the conference with counsel September 14, 1977, 'since Medicaid has become a permanent feature of American life for the foreseeable future, it is important that a court declare whether there is judicial authority to review the action of HEW in approving state plans and, if so, to establish by what standards such approval are to be granted or withheld.

Although it is true that in 1977 the state made substantial amendments to the 1976 plan here under attack, nevertheless, major features of the 1976 plan remain in effect. More to the point, however, is the fact that if a violation has occurred on the part of HEW there is a "cognizable danger of recurrent violation" unless the court grants relief. United States v. W. T. Grant Co., 345 U.S. 629 (1953). If HEW has acted unlawfully this court has the power to compel appropriate action. Administrative Procedure Act, 5 U.S.C. §706(1). Kingsbrook Jewish Medical Center v. Richardson, 486 F.2d 663, 668



(2d Cir. 1973); Mandley v. Trainor, 545 F.2d 1062, 1072  
(7th Cir. 1976).

For the reasons stated, the motion is denied.

It is so ordered.

Dated: New York, New York  
November 18, 1977.

MORRIS E. LASKER

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U.S.D.J.



APPENDIX B



## APPENDIX B

The hospitals' brief argues the merits of their challenge to several provisions of the state's reimbursement formula, although the merits are not involved in this appeal and have not been tried below. This Appendix makes no effort to answer all the points advanced in the hospitals' argument. Rather, it sets forth for the benefit of the Court the primary justification for the major provisions under attack. These justifications are based on the three criteria identified in the HEW regulations (45 C.F.R. § 250.30(a)(2)(ii)) as applicable to the statutory "reasonable cost" standard:

- (a) incentives for efficiency and economy,
- (b) reimbursement on a reasonable cost basis, and
- (c) assurance of adequate participation of hospitals and availability of hospital services of high quality to Medicaid recipients.

A principal purpose of the prospective reimbursement rate methodology is to create incentives for efficiency and economy in hospital operations. Under the New York system, this is accomplished primarily by predicated the rate for any year on the costs experienced two years previously projected forward to take account of inflation



and other factors in accordance with "trending" techniques. To the extent a hospital is able to control its costs in the rate year so that they are below those experienced in the base year (as projected forward), it can earn a "profit" on its Medicaid services. This is one incentive to efficient operations inherent in the approach. A second incentive lies in the fact that costs incurred in the rate year in excess of base period costs (trended forward) will not be reimbursed and must be borne entirely by the hospital. The methodology contains an appeals mechanism which permits rate adjustment for exceptional factors that any hospital may demonstrate.

1. Section 86-1.14(b). This section contains the ceiling provisions that have drawn most of the hospitals' attack in this case. For several years, the methodology has incorporated a concept of a peer-group ceiling for "routine" hospital costs -- those associated with the housing, feeding and routine handling of patients. Hospitals are grouped in accordance with comparability factors, and the routine costs of the hospitals in this group are averaged. Prior to 1976, reimbursement for the routine costs of any hospital was limited to no more than 110 percent of the peer-group average. Because this provision had not provided sufficient incentive for efficiency



and economy, the 1976 changes reduced the percentage to 100 percent. In addition, they established a similar peer-group ceiling, also at the 100 percent level, for ancillary costs -- those associated with the medical procedure or other treatment afforded the patient.

The hospitals have not challenged the concept of ceilings. Their main objection is that the 100 percent ceilings necessarily preclude full-cost reimbursement for approximately half of the hospitals (those whose costs exceed the group average) even though those hospitals may be operating efficiently. This is not how the system works. As shown, the ceilings are derived from costs experienced in the base period. A hospital that is able in the rate year to control its costs and bring them in line with the group average will not suffer in the rate year.

An important element in the ceiling approach is the method of grouping hospitals. Initially, the hospitals attacked the grouping methods in the 1976 formula. Those provisions were substantially modified in 1977 to take account of additional factors and to provide even more precise groupings.



Studies undertaken in 1976 showed that almost all hospitals could avoid any ceiling impact by reducing their costs only slightly (no more than two percent in most cases). This supported the state's conclusion that the revised ceilings would not jeopardize hospital participation in the Medicaid program nor reduce the quality of service available to Medicaid recipients. Experience has borne out this view. Moreover, discovery in this case has shown that the methodology has worked as planned, and that hospitals have undertaken cost control measures that have produced or should produce reductions in expenditures with no reduction in quality of service. As hospitals generally evolve to more efficient operation, eliminating excessive expenditures and controlling cost increases, the ceiling approach will undoubtedly be reexamined. The continuing need for the incentives contained in the present ceilings depends on the effectiveness of the hospitals' response and the strength of their commitment to bring and maintain their costs under control.

2. Section 86-1.13(c). This provision relates to the calculation of the average costs of a group of hospitals for purposes of the ceilings. The 1976 version provides that hospitals whose costs are above 125



percent or below 75 percent of the originally computed average will be excluded and the average recalculated without them. The purpose is to protect the integrity of the ceiling computations by eliminating hospitals whose costs appear to be aberrant. This provision has been recently modified to provide that only the costs in excess of 125 percent or below 75 percent will be excluded from the average computations (rather than all of the costs for the aberrant hospitals). This approach, called "centralizing," is a well-recognized mathematical technique. It can cause the ceilings for any particular group to be slightly higher or slightly lower. It enhances the ceiling incentives by insuring that they are based on a more accurate peer-group standard.

3. Section 86-1.26. This section authorizes the exclusion from reimbursable costs of a portion of the salary and fringe benefits for interns and residents that is "properly chargeable to education activities not directly related to patient services." This affects teaching hospitals, whose interns and residents spend a portion of their working time in teaching or learning functions not directly related to the care of patients. These functions are of benefit to the hospital. The teaching function reduces the hospital's need to hire faculty and



the learning function enhances the capabilities of residents and interns who are the prime source for the hospitals' professional house staffs. While these functions are valuable, the state is not obliged under its Medicaid reimbursement formula to subsidize expenses relating to them; hence this provision of the formula.

4. Section 86-1.21(k). The prospective methodology approach is predicated on base period costs "trended" forward to take account of inflation and other factors. The trending is normally based on economic indicators, such as indices of wages and other cost components. This approach incorporates the additional incentive to hospitals to keep their cost increases within or below the levels of the economic indicators. This incentive would be undercut if increases which exceeded the trend factors and were excluded from reimbursement in a particular rate year could later be reimbursed when that earlier year became the base year. For example, 1977 rates are based on 1975 actual costs trended forward. If in 1978 the rate were based on 1976 actual costs even where the increase from 1975 to 1976 exceeded the amount permitted by the trending factor, there would be less incentive to keep the increases under control.



For this reason, section 86-1.21(k) provides that for 1978 and later years the base costs will be the actual costs incurred in 1975 increased by the trending factor in those cases where actual increases are greater than the amount permitted by the trending factor. If a hospital sufficiently controls its costs to keep its increases within the limits of the trending factor, it will not be adversely impacted by this provision. This provision specifically permits an exception to allow for rate increases to take account of approved new or expanded services subsequent to the base year.

The main challenge of the hospitals in this case has been addressed to the foregoing provisions of the formula. Of the other provisions that are in issue, brief comment will suffice to show their purpose and justification.

5. Section 86-1.31. This section requires hospitals to notify the state of the deletion or withholding of services. It does not bear on hospitals efforts to reduce the costs associated with services they continue to provide. Discovery to date shows that the hospitals' response to the incentives in the state's formula has focused principally on reducing costs while maintaining the quality and level of service.



6. Section 86-1.15(b). This relates to equipment lease costs and interest and depreciation associated with equipment. The formula recognizes that these costs are usually fixed by contract, in the case of leases, or cannot be altered through normal cost control efforts, in the case of equipment already purchased. Accordingly, it provides that these costs are not subject to the ceiling computations; hospitals are entitled to their full base period costs in these categories. To avoid a windfall to the hospitals, it is likewise provided that the trending factor applied to base period costs will not apply to these costs, in view of their fixed nature.

7. Section 86-1.8(i). This section authorizes certain penalties in case of overpayments to hospitals resulting from non-compliance with reporting requirements. This is a reasonable administrative measure to encourage prompt and proper reporting by hospitals. It does not affect the calculation of the reimbursement rate. The section also provides that all overpayments shall bear interest. This is a reasonable measure to insure that hospitals do not enjoy free use of state funds to which they are not entitled.

8. Section 86-1.21(i). This provision eliminates from reimbursement the cost of any penalties



(including interest on penalties or on overpayments) imposed by a governmental agency or court. This is necessary to insure that the taxpayers do not bear the burden of penalties assessed against hospitals.

9. Section 86-1.17. This establishes an appeals mechanism that allows hospitals to obtain adjustments to their formula rates based on showings of exceptional circumstances. The hospitals do not question the desirability of such a mechanism. They do claim it is improper for the rate-setting agency to determine requests for exceptional treatment. The approach of the formula is consistent with many rate-setting agencies at the federal and state levels. The hospitals also assert that because over half of the hospitals could be impacted by the 100 percent ceiling provisions, these hospitals could also invoke the appeals procedure, which would convert the appeals process into the ratemaking process in alleged violation of federal law. As shown above, the premise of this contention is erroneous, for most hospitals are well able to respond to the ceiling incentives and control their costs sufficiently to avoid a substantial ceiling impact. The appeals procedure is available for those relatively few cases where unusual circumstances preclude avoidance of the impact notwithstanding vigorous cost containment efforts.



10. Out-Patient Rates. The hospitals' arguments on this subject are addressed to the wrong forum, for out-patient rates are not subject to the reasonable cost standard of section 1902(a)(13)(D) of the Social Security Act (42 U.S.C. § 1396a(a)(13)(D)).



COVINGTON & BURLING

888 SIXTEENTH STREET, N. W.

WASHINGTON, D. C. 20006

TELEPHONE (202) 452-6000

WRITER'S DIRECT DIAL NUMBER

452-6290

December 5, 1977

HOWARD C. WESTWOOD  
JOHN T. SAPIENZA  
JAMES H. MCGLOTHLIN  
ERNEST W. JENNES  
STANLEY L. TEMKO  
DON V. HARRIS, JR.  
WILLIAM STANLEY, JR.  
WEAVER W. DUNNAN  
EDWIN M. ZIMMERMAN  
JEROME ACKERMAN  
HENRY P. SAILER  
JOHN H. SCHAFER  
ALFRED H. MOSES  
JOHN LEMOYNE ELLICOTT  
PAUL R. DUKE  
PHILIP R. STANSBURY  
CHARLES A. MILLER  
RICHARD A. BRADY  
ROBERT E. O'MALLEY  
EUGENE I. LAMBERT  
JOHN VANDERSTAR  
NEWMAN T. HALVORSON, JR.  
HARVEY M. APPLEBAUM  
MICHAEL S. HORNE  
JONATHAN D. BLAKE  
CHARLES E. BUFFON  
ROBERT N. SAYLER  
E. EDWARD BRUCE  
DAVID N. BROWN  
PAUL J. TAGLIABUE  
ANDREW W. SINGER  
DAVID H. HICKMAN  
RUSSELL H. CARPENTER, JR.  
NICHOLAS W. FELS  
THEODORE L. GARRETT

CHARLES A. HORSKY  
W. CROSSBY ROPER, JR.  
DANIEL M. GRIBBON  
HARRY L. SHNIDERMAN  
EDWIN S. COHEN  
JAMES C. MCRAE  
JOHN W. DOUGLAS  
HAMILTON CAROTHERS  
J. RANDOLPH WILSON  
ROBERTS B. OWEN  
EDGAR F. CZARRA, JR.  
WILLIAM H. ALLEN  
DAVID S. ISBELL  
JOHN B. JONES, JR.  
H. EDWARD DUNKELBERGER, JR.  
BRUCE McADDOO CLAGETT  
JOHN S. KOCH  
PETER BARTON HUTT  
HERBERT DYM  
CYRIL V. SMITH, JR.  
MARK A. WEISS  
HARRIS WEINSTEIN  
JOHN B. DENNISTON  
PETER J. NICKLES  
MICHAEL BOUDIN  
BINGHAM B. LEVERICH  
ALLAN J. TOPOL  
VIRGINIA G. WATKIN  
RICHARD D. COPAKEN  
CHARLES LISTER  
PETER D. TROBOFF  
WESLEY S. WILLIAMS, JR.  
DORIS D. BLAZEK  
WILLIAM D. IVERSON

NEWELL W. ELLISON  
JOHN G. LAYLIN  
H. THOMAS AUSTERN  
FONTAINE C. BRADLEY  
EDWARD BURLING, JR.  
J. HARRY COVINGTON  
COUNSEL

JOHN SHERMAN COOPER  
OF COUNSEL

TWX: 710 822-0005  
TELEX: 89-593  
CABLE: COVLING

United States Court of Appeals  
for the Second Circuit  
Room 1903  
United States Courthouse  
Foley Square  
New York, New York 10007

Re: Hospital Association of New York State,  
Inc., et al. v. Philip L. Toia, et al.,  
Nos. 77-6152 and 77-6174

Dear Sir:

Enclosed for filing are twenty-five copies  
of the State Defendants-Appellees briefs in Civil  
Appeal Nos. 77-6152 and 77-6174. Copies of the fore-  
going have been served by hand on Appellants' counsel:

Jacob Imberman, Esq.  
Proskauer Rose Goetz & Mendelsohn  
300 Park Avenue  
New York, New York 10022

and by mail on counsel for other parties appearing below:

Peter F. Nadel, Esq.  
Rosenman, Colin, Freund,  
Lewis & Cohen  
575 Madison Avenue  
New York, New York 10022

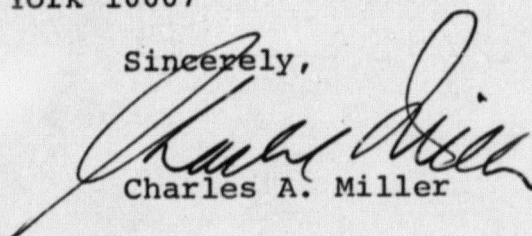


COVINGTON & BURLING

United States Court of Appeals  
for the Second Circuit  
December 5, 1977  
Page Two

John M. O'Connor, Esq.  
Assistant United States Attorney  
United States District Court  
United States Courthouse, Annex  
One St. Andrews Plaza  
New York, New York 10007

Sincerely,

A handwritten signature in dark ink, appearing to read "Charles A. Miller", is written over the typed name.

Charles A. Miller

mb  
Enclosures